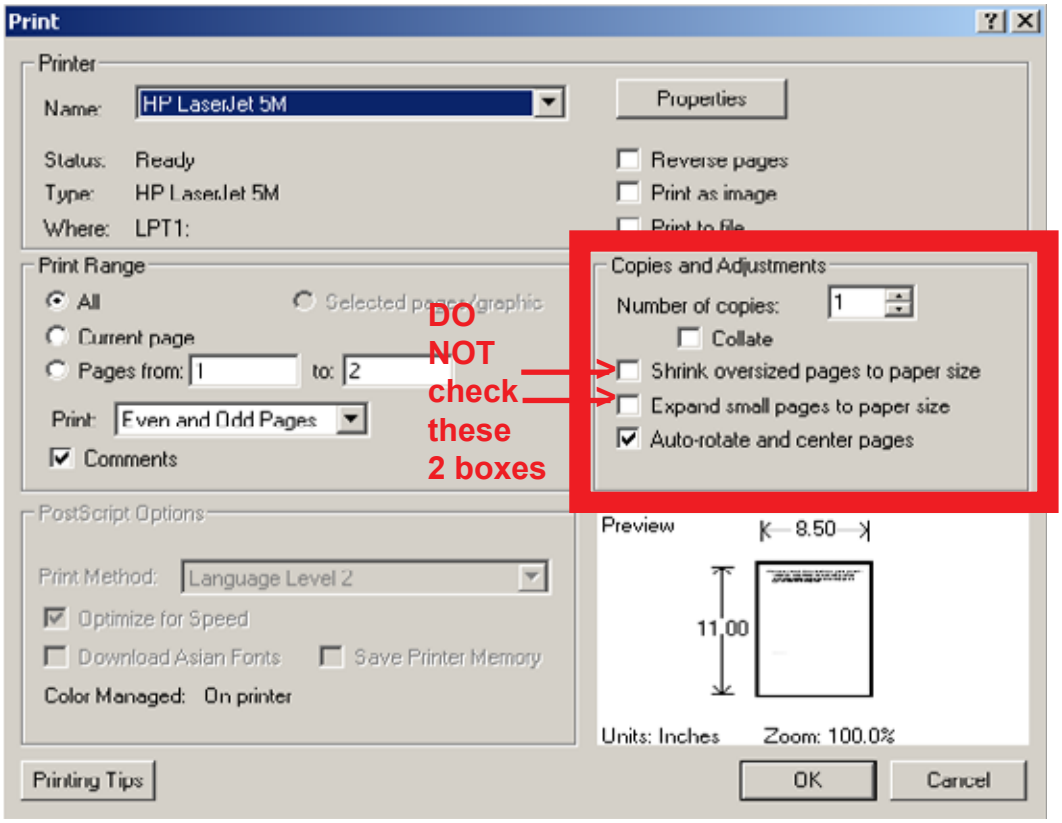
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Nursing Assistant Registered Application Packet

1. 667-025 ..... Contents List/SSN Information/Deposit Slip ..... 1 page
2. 667-002 ..... Instructions for Application for Nursing Assistant Registered Credential ..... 2 pages
3. 667-019 ..... Important Information Regarding Personal Data Questions ..... 1 page
4. 667-001 ..... Application for Nursing Assistant Registered Credential..... 4 pages

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your *application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Nursing Assistant Registered

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check No.** _____
☐ **Money Order**

DOH 667-025 (REV 7/2006)

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Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Instructions for Nursing Assistant Registered

Your application for Nursing Assistant Registered will be completed once the following requirements have been met. It is important that the application is completed in full, either typed or **clearly** printed. This will avoid any delay in the registration process. Pencil or photocopies are not acceptable.

Section 1

- Type, or print clearly, your name, street address and telephone number. If your address changes at any time after you have filed your application, it is your responsibility to notify the Department of Health. See WAC 246-12-310.
- Indicate whether you are known or have been known under any other names. If you have a name change, it is your responsibility to notify the Department of Health in writing along with acceptable documentation. See WAC 246-12-300.
- Indicate your social security number. Your application cannot be processed without this identifying information. It is required under Federal and state statute (42 USC 666 and Chapter 26.23 RCW).
- Complete the remaining identifying information.

Section 2

The State of Washington requires a minimum of seven (7) hours of HIV/AIDS education prior to registration (RCW 18.130). If you feel you have met this requirement through continuing education, your original program of study, on-the-job training, etc., **you may sign** the portion of your application that asks for attestation.

If you feel you have not met this requirement, refer to the enclosed attachment summarizing some of the AIDS courses available throughout the state. Upon completion, keep a copy of your certificate for further personal/professional reference.

Section 3

The Personal Data questions must be completed by each applicant. If you indicate “Yes” to any question attach a copy of any and all judgments, decisions, orders, agreements and surrenders.

Section 4

Read this section carefully. Omission of any pertinent information may be cause for denial of your application or registration. Sign in ink and date the application.

Fees

The application fee is $15.00. Make your check or money order payable to Department of Health. The application fee is non-refundable.

Return form to: Department of Health
Nursing Assistant Program
P.O. Box 1099
Olympia, WA 98507-1099

If you have any questions, call (360) 236-4700.

You may also access The Department of Health website at http://www.doh.wa.gov/, then choose Nursing Assistants under Topics A-Z.

Processing Time

The average processing and mailing time for a complete application is approximately four (4) weeks. Please allow staff at least four full weeks to process your fee, application, and mail your registration before you call.

HIV/AIDS Information
AIDS Education Requirements For Health Related Professions

All health related professions under the disciplinary authority of the Uniform Disciplinary Act (RCW 18.130) are affected. This requirement went into effect January, 1989.

The topics that must be covered by this requirement are: *etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and psychosocial issues to include special population considerations.* The course must be seven (7) hours or more in length.

If you completed your nursing program in 1989 or later and completed this requirement in the nursing courses, or a CE course, etc., after this time, you may complete the attestation portion of your application which specifies you have met this requirement. Keep documentation of completion for future reference. You may need to show proof to an employer.

If you feel you have not met this requirement, or you cannot document that you have, you can meet this requirement through a correspondence course or a community college. A partial listing of available offerings follows:

Robert D. Anderson Publishing Company
1-800-532-2332

Washington State University
Intercollegiate College of Nursing
1-800-281-2589

University of Washington
(206)543-1047

Impact Inc.
(206) 284-3865

Department of Health
AIDS Information Hot Line
1-800-272-2437
Website: 667-001 http://www.doh.wa.gov/cfh/hiv_aids/prev_edu/training.htm

New York State Nurses Association
(518) 782-9400
E-mail: info@nysna.org
Website: http://www.nysna.org

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Important Information Regarding Personal Data Questions

This page contains important questions and answers concerning the personal data questions. You will be held responsible for this information.

1. **For questions 5a, 5b and 5c, do I need to reveal a conviction that is over three years or over five years old?**

   Yes, this question asks if you have **ever** been convicted, etc. of any crime other than a minor traffic violation.

2. **For questions 5a, 5b and 5c, do I need to reveal a conviction that is not a felony?**

   Yes, you must reveal all convictions even if they were a misdemeanor or seem minor. The only exception to this is minor traffic infractions. You must, however reveal a DUI or a Reckless Driving Conviction.

3. **But I've been told that I don't need to reveal certain crimes if it's been over a certain amount of time or that I don't need to reveal any crimes not on the "List of Disqualifying Crimes".**

   That information is incorrect. Be aware that this "Disqualifying Crimes" for the Department of Social and Health Services **does not apply** to this application with the Department of Health.

4. **What is the difference between the Department of Social and Health Services and the Department of Health?**

   The Department of Social and Health Services ensures that a nursing assistant meets Federal requirements to work in a Nursing Home. The Department of Health makes sure a Nursing Assistant meets additional state requirements to work in any setting. The laws each Department follows are different. This is why the DSHS disqualifying list does not apply to the Department of Health's criteria.

5. **What happens if I answer" no" to a question I should have answered "yes" to?**

   The Department of Health can issue an "Intent to Deny" your application for registration or certification based on a deceptive answer. You will have the chance to respond and, if necessary, go to a hearing regarding this matter. Be aware that this process can be quite lengthy.

   If you are granted a registration and/or certification based on deceptive answers to the personal data questions and the Department later finds out about this, disciplinary action can be taken against your registration and/or certification at that point in time. This means your credential could be revoked based on inaccurate information on your original application.

6. **Do I need to send documentation when I answer "Yes" to questions 5, 6, 7, 8 or 9?**

   Yes, you must provide a signed and dated statement of explanation and copies of all judgements, decisions, orders, agreements or surrenders. **If you do not send this documentation with your application, it will delay the processing of your application.**

7. **What if I am convicted of a crime after I submit my application and/or receive my registration/certification?**

   You are required by RCW 18.130.070 (4) to report any conviction, determination or finding that you have committed unprofessional conduct or are unable to practice with reasonable skill and safety.

The Department of health does criminal background checks on **all** applicants.

If you do not understand the above information, please contact the Department of Health at (360) 236-4700.

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY
CANDIDATE NUMBER
LICENSE DATE

REGISTRATION #

Application For Nursing Assistant Registered Credential

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee which is **non-refundable**. Make remittance payable to the Department of Health. Individuals who wish to work in a health care facility must **register** within three days of employment with the **State of Washington Department of Health**. **A separate application is required for certification.**

1. Demographic Information

APPLICANT'S NAME | LAST | FIRST | MIDDLE INITIAL

LIST OTHER NAMES USED

MAILING ADDRESS (MUST BE RESIDENT'S ADDRESS, **NOT** BUSINESS) | EMAIL ADDRESS (OPTIONAL)

CITY | STATE | ZIP | COUNTY

NOTE: Your registration document will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL** BUSINESS HOURS.) ( )

RESIDENCE TELEPHONE ( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW) — —

GENDER ☐ Female ☐ Male

Birthdate (Month/Day/Year) **(REQUIRED)**

2. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS, either through my professional education or through the completion of DSHS required training for caregivers or staff employed in DDD Certified Residential Programs, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification or registration may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

4. Applicant's Attestation

I, _____ , certify that I am the person described and identified in this
NAME OF APPLICANT

application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and my independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my certification or registration to practice in the State of Washington.

Signature of Applicant _____ Date _____

Official Use Only

Washington State Records Center